INDIANA FIRST STEPS EARLY INTERVENTION SYSTEM

First Steps is administered by the Bureau of Child Development within the Division of Family and Children of Indiana's Family and Social Services Administration (FSSA). Indiana's First Steps System is a family-centered, culturally sensitive, locally based, coordinated system that provides early intervention services to infants and young children with disabilities or who are developmentally vulnerable. First Steps brings together families and professionals from education, health and social service agencies. The statewide early intervention system is designed to support families in fulfilling their natural roles of care giving, guiding and nurturing. By coordinating locally available services, First Steps is working to give Indiana's children and their families the widest possible array of early intervention resources. Parents and professionals develop an Individualized Family Service Plan (IFSP) based on family resources, priorities and concerns to decide what services will achieve the best possible results for the child.

Families who are eligible to participate in Indiana's First Steps System include children ages birth to three years old who:

- Are experiencing developmental delays
- Have a diagnosed condition that has a high probability of resulting in a developmental delay
- Are at risk of having substantial developmental delay as a result of biological risk factors if early intervention services are not provided

Services available to eligible children and their families include: developmental therapy, speech-language pathology, physical and occupational therapy, audiology, assistive technology, and service coordination, among others. All services are coordinated with the eligible child's primary medical provider.

Children enter the system through the System Point of Entry (SPOE) in each county. Intake coordinators facilitate eligibility determination and development of an Individualized Family Service Plan. Families complete a common intake form that supports access to First Steps, Children's Special Health Care Services (CSHCS), Maternal and Child Health (MCH) programs and Hoosier Healthwise (Medicaid) programs.

The System Point of Entry (SPOE) for First Steps is responsible for:

- Assisting the family in selecting a PMP if they have none.
- Monitoring re-screen and follow-up, and intervention
- Intake and enrollment of the family into the First Steps System and other agencies as needed
- Assignment of a Family Service Coordinator as needed
- Reporting monitoring results to ISDH as required

FOLLOW-UP REFERRAL FOR AUDIOLOGY SERVICES

State Form 53335 (7-07)
Maternal and Children's Special Health care Services (MCSHCS)
Newborn Screening

First Steps

CONFIDENTIAL INFORMATION PER IAC 21-3-7 / 410 IAC 21-3-9

Name of Child:_____
Date of Birth *(month, day, year)*:_____
Check One: ☐ Male ☐ Female ☐ Ambiguous

Name of Parent/Guardian:_____
Address *(number and street)*:_____
City, State, ZIP Code:_____
Telephone Number_____
County of Residence _____
Other Contact Information:_____

Name of Referring Hospital / Referring Physician :_____
Telephone Number:_____

Primary Care Physician (*responsible for follow-up care*):_____
Address *(number and street)*:_____
City, State, ZIP Code:_____
Telephone Number:_____

RESULTS	Type of Test	Date Completed	Right Pass / Fail	Left Pass/ Fail
Initial Hearing Screening(s)				
Diagnostic / Confirmatory Testing				

Referral for high risk / delayed on-set hearing loss

Reason:
- ☐ Family History of Permanent Childhood Hearing Loss
- ☐ Congenital Infection (*e.g. cytomegalovirus, herpes, rubella, syphilis, & toxoplasmosis*)
- ☐ Hyperbilirubinemia requiring Exchange Transfusion

REFERRAL APPOINTMENT SCHEDULED: ☐ Yes ☐ No (If yes, *complete below*)
Date of Referral Appointment *(month,day,year)*:_____
Address of Agency / Physician:_____
City, State, ZIP Code: _____
Telephone Number:_____

Completed By: _____ **Telephone:** _____ **Date:**_____

Send form to the local System Point of Entry - First Steps, or Fax to First Steps State Office 317-233-6093 or call 1-800-441-4837 *(Indiana Residents Only)*

GENERAL RECIPROCAL CONSENT TO RELEASE AND SHARE INFORMATION (*Page 1*)

State Form 51675 (R2 / 2-05) / BCD 0108
Indiana Family and Social Services Administration
Maternal Child Health Services / Hoosier Healthwise
First Steps Early Intervention System / Children's Special Health Care Services (CSHCS)

First Steps
Indiana Children's Special Health Care Services

Please review the information on page 2 of this form, and have your Intake/Service Coordinator discuss any questions that you may have before signing below.

I/We _____ give my/our informed consent for:
(*Name(s) of parent/legal guardian*)

Name	Telephone	Fax number
	( )	( )

Name of agency (*if applicable*)	Address (*number and street, post office box*)

City/Town	State	ZIP code

to communicate and to share information, in writing and conversation, with the First Steps Early Intervention System and Children's Special Health Care Services regarding:

Legal name of child	Date of birth (*month, day, year*)

Address (*number and street, post office box*)	County

City/Town	State	ZIP code

The consent includes the following types of information and activities: (*as checked* ✓)

☐ Access to the early intervention record information (*including obtaining copies of written specialty reports, the IFSP, progress reports and other communications*) required to determine eligibility, participate in service planning, and/or provide early intervention services as defined in the Individualized Family Service Plan (IFSP).

☐ Other: _____

I HAVE READ AND UNDERSTAND THE CONDITIONS OF THIS RELEASE, AS CONTAINED ON PAGE 2 OF THIS FORM.

Signature of parent/legal guardian/surrogate parent	Date (*month, day, year*)

Signature of parent/legal guardian/surrogate parent	Date (*month, day, year*)

Signature of witness	Date (*month, day, year*)

Please read this carefully before signing. If you have questions, please ask your Intake or Service Coordinator.

The purpose of this release is to collect information necessary to determine my child's eligibility for the programs listed above, and to plan and provide essential and necessary services as determined through the multidisciplinary team process. I hereby authorize the person named on the reverse side of this form to release to the staff of First Steps and/or Children's Special Health Care Services upon presentation of this form, any records or information pertinent to the development and implementation of a plan for service to meet the medical, educational, developmental, social and rehabilitative needs for the child named on this release.

I also give consent for the release of information by First Steps and/or Children's Special Health Care Services to accomplish referrals for service to other individuals where an informed, written consent has been obtained from me; and to ensure ongoing service delivery in accordance with the IFSP through routine communications including report distribution, participation in IFSP meetings, planning and review activities.

I understand that this consent includes the sharing of information as authorized above in written, verbal and/or video format. This consent is effective for a period up to twelve (12) months from the date of my signature on this release. As the parent/legal guardian or surrogate parent, I understand that I may revise or revoke this release of information/consent to communicate at any point in time through the Service Coordinator indicated on the current IFSP.

The information collected as a result of this consent shall be maintained in my child's record which will be located at the System Point of Entry for the First Steps Early Intervention System and/or CSHCS, the Indiana State Department of Health. This record is subject to the provisions of the Family Educational Rights and Privacy Act (FERPA) and, as such, is available for my review and may be reproduced or corrected upon my request. All personal information collected will be treated as confidential pursuant to I.C. 4-1-6 et seq., I.C. 5-14-3-4 and 410 IAC 3.2-10.